PREVALENCE, PATTERN AND DETERMINANTS OF WORKPLACE VIOLENCE AGAINST NURSES IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY (MBBS) DEGREE IN THE UNIVERSITY OF BENIN, BENIN CITY

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DEDICATION

This project is dedicated to God Almighty for His strength and mercies freely bestowed upon us, from the commencement of this work up till its completion.

We also dedicate this work to our respective loved ones for their unwavering support thus far, and to all the nurses who willingly participated in this survey.

DECLARATION

We hereby declare that this work, "Prevalence, Patterns and Determinants of Workplace Violence Against Nurses in the University of Benin Teaching Hospital" was originally carried out by us, under supervision of Prof. A.N. Ofili and Dr. O.H.N. Okwara. It is original, except otherwise stated and has never been submitted anywhere else for any purpose before.

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CERTIFICATION

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LIST OF ABBREVIATIONS

CINAHL: Cumulated Index to Nursing and Allied Health Literature

EDs: Emergency departments

HCWs: Healthcare workers

ICN: International Council of Nurses

ILO: International Labour Organization

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PSI: Patient Safety Incidents

PTSD: Post-traumatic Stress Disorder

SPSS: Statistical Package for the Social Sciences

UBTH: University of Benin Teaching Hospital

UIIPRC: University of Iowa Injury Prevention Research Centre

WHO: World Health Organization

WPV: Workplace violence

DEFINITION OF TERMS

ASSAULT: An attempt with force or violence to do a corporal injury to another; may consist of any act tending to such corporal injury, accompanied with such circumstances as denotes at the time an intention, coupled with present ability, of using actual violence against the person.

HARASSMENT: Illegal behaviour towards a person that causes mental or emotional suffering, which includes repeated unwanted contacts without a reasonable purpose, insults, threats, touching, or offensive language.

VIOLENCE: The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

WORKPLACE VIOLENCE AGAINST NURSES: Any harmful act Physical, sexual, or psychological committed against the nurses in the workplace by a patient or visitor.

ABSTRACT

BACKGROUND: Workplace violence against nurses has had significant impact on the health sector worldwide, including Nigeria. Although measures have been put in place, in a bid to curb its occurrence, it still remains a major public health concern.

OBJECTIVES: This study identified the prevalence, pattern and determinants of workplace violence against nurses in the University of Benin Teaching Hospital (UBTH), with a view to provide data for appropriate policy formulation to promote a better workplace atmosphere.

METHODOLOGY: A descriptive cross-sectional study design was carried out among 346 Nurses in the UBTH, Benin city, Nigeria. Respondents were selected using Stratified sampling method. Data was collected using a structured self-administered questionnaire. The data was analyzed using IBM SPSS version 25, with the level of significance set at $p < 0.05$.

RESULT: The mean age of the respondents was 37.7±10.9 years. There were 290 (83.8%) females, and more than half, 210 (60.7%), were married. Majority, 270 (77.6%) had experienced workplace violence at least once in their careers, and overall, 222 (64.2%) of the respondents had a high prevalence of workplace violence. The one-year prevalence rate of workplace violence was 71.9% (194). The highest determinant and measure indicated were unrealistic expectations of patient relatives (93.6%) and controlling the number of visitors (93.9%), respectively. Age ($p = 0.001$), marital status ($p = 0.002$), and years of experience ($p = <0.001$) were found to have significant associations with the overall prevalence.

CONCLUSION: Majority of the respondents had experienced workplace violence, verbal abuse was most common form and patient relatives, the highest perpetrators. The highest determinant and measures to curb workplace violence were the unrealistic expectations of patient relatives and controlling the number of visitors respectively.

Keywords: Prevalence, Patterns, Determinants, Workplace Violence, Nurses.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Violence against healthcare workers (HCWs) is a global phenomenon and was declared a major public health problem in the Forty-ninth World Health Assembly in 1996[1] and since then, there has been an increase in the reports of assault against healthcare providers in the world, sometimes leading to grievous hurt or murder[2] with more in the developing countries where the condition of care and service is deplorable.[3]

World Medical Association has most recently defined violence against health personnel as, "an international emergency that undermines the very foundations of health systems and impacts critically on patient's health". [4] The University of Iowa Injury Prevention Research Centre (UIIPRC) has categorized workplace violence into four major types, including Criminal intent (Type I), Customer/client (Type II), Worker-on-worker (Type III), and Personal relationship (Type IV).[5]

Compared to other occupations, healthcare workers are at higher risk for various kinds of violence in the workplace, due to the nature of the healthcare settings and overstressed people.[6] Workplace violence in the medical occupations thus represents a significant proportion of all workplace violence incidents. [7] Nurses, in particular, are at especially high risk due to their frontline position and constant contact with patients and their relatives.[6]

Nurses are an essential part of the health care team and play pivotal roles in the healthcare system with their duties ranging from direct patient care, which involves observing and monitoring the patient and recording any relevant information, to aid in treatment decision-making processes to administering medications, conducting frequent medical examinations, and ensuring patients' comfort as much as possible during the hospital admissions and helping with patient education and support.

They are frequently referred to as the "Ward Managers", as they serve to oversee the various activities carried out in the wards in the process of providing care to patients. They also play the role of intermediaries/mediators helping for flow of information between the doctors/physicians, patients and patient relatives, thus helping to coordinate care of the patient.

Violence against healthcare workers, especially nurses, can have an adverse effect on their performance outcomes and thus influence patients' health and satisfaction. The consequences of violence vary widely. Studies have shown about seven categories of consequences of workplace including physical, psychological, emotional, work functioning, relationship with patients/quality of care, social/general, and financial. These may restrict the satisfaction, health, and performance of employees over the longer term and result in lower job satisfaction and an increase in the number of sick days.[8] This also negatively impacts patients who are deprived of good, quality care responsive to their genuine needs in time of trouble.[9]

Sadly, the rates of workplace violence against nurses remain underreported due to a widely held belief among nurses that violent incidents are a regrettable, but inevitable part of their profession.[6]

The aim of this study is to determine the prevalence and pattern of violence against nurses in a tertiary hospital in a Nigerian city. It is also to identify the determinants of violence and to assess the measures taken to curb violence against nurses.

1.2 STATEMENT OF THE PROBLEM

Workplace violence has become an endemic problem in health care, and nurses are particularly at a higher risk of abuse.[10] Workplace violence affects psychological health, and physiological well-being and in some cases leads to death.[11] Physical injuries have been revealed to be one of the adverse effects of workplace violence.

Regarding the prevalence of workplace violence against nurses, a secondary analysis of cross-sectional survey data from 537 medical-surgical nurses from British Columbia, Canada, showed that on average, nurses were exposed to workplace violence a few times a year; reported high levels of emotional exhaustion; experienced musculoskeletal injuries and anxiety disorders once a month and sleep disturbances a few times a month.[10] Similarly, a study in China to assess the prevalence of symptoms of Post Traumatic Self Disorder among Chinese health care workers, showed that 21.2% of the victims of physical violence were at risk for developing PTSD and 28.0% met the full diagnostic criteria for PTSD.[12]

Another review was done in Seoul, South Korea, on 16 cross-sectional studies on violence against psychiatric nurses. It showed that psychiatric nurses who experienced workplace violence had primarily poor mental health such as depressive symptoms and negative work-related outcomes such as turnover intention. .[13] Similarly, a study across five European countries

revealed that a large number of nurses had been physically attacked or verbally abused at work, primarily by patients and their relatives, highlighting the widespread nature of this issue.[14]

The prevalence of work place violence differs from country to country: In Egypt, the prevalence of verbal abuse and physical abuse among nurses was 69.5% and 9.3% respectively. [11] The consequences of violence against Health Care Workers can be very serious: deaths or life-threatening injuries, reduced work interest, job dissatisfaction, decreased retention, more leave days, impaired work functioning, depression, post-traumatic stress disorder, decline of ethical values, increased practice of defensive medicine. Workplace violence is associated directly with higher incidence of burnout, lower patient safety, and more adverse events.[15]

The prevalence of workplace violence against nurses has been extensively documented in various studies, shedding light on the alarming rates of physical, verbal, and sexual abuse experienced by nurses in their line of duty. [14,16,17] Numerous studies have highlighted the prevalence of workplace violence against nurses, with findings indicating that a substantial percentage of nurses have been exposed to violence within the past year. For instance, a study in the Gambia reported that 62.1% of nurses experienced workplace violence, with a significant proportion facing physical violence, verbal abuse, and sexual harassment.[16]

Concerning the patterns of workplace violence against nurses, it was observed that in three Italian university schools of nursing, verbal violence was associated with high levels of psychological problems. It was also associated with high job strain, low social support, and low organisational justice, but only among nursing students.[18]

Decreased work productivity is also a major consequence of workplace violence. A study done on the pattern of violence against nurses in two hospitals in Ibadan, Oyo, showed that 49 (15.6%) experienced physical violence without a weapon, 39 (12.4%) experienced verbal harassment and bullying. Attackers of 33 (10.5%) were patient relatives. Decreased work productivity due to workplace violence was reported among 60 of them (19.1%) while no change in work productivity was reported among 170 (54.1%).[19]

Regarding the determinants of workplace violence against nurses, a study showed that the victims of physical violence were most frequently clinical nurses, and this was due to the fact that clinical nurses provide direct patient care and are involved in close interaction with patients and their family. The study also suggested that mental state of the patient played a huge role in whether or not the nurses would suffer workplace violence.[20] It has also been observed, in certain regions, that mental deterioration occurred as a result of acts of violence done against the health workers, particularly the nurses. Experiencing violence at work may cause a decline in the physical and mental state of the health workers and can result in reduced productivity and an overall lack of enthusiasm towards the observation of proper procedures negatively impacts, both at the organisational and individual level, as well as the work place. This could eventually result in a hostile work climate and suboptimal patient care.[13]

Workplace violence has increased over time. However, when it comes to the measures taken to curb the occurrence, it has been recorded that a larger percentage of health care workers do not report cases of workplace violence for several reasons. Some of which include the fear of retaliation from the patient, an inadequate reporting system, or lack of follow up by the management.[21]

1.3 JUSTIFICATION

Workplace violence against nurses is a pervasive and concerning issue that has been extensively documented in the literature globally, including in Nigeria. Studies have reported alarmingly high rates of physical, verbal, and sexual abuse experienced by nurses in their line of duty. For instance, a study in the Gambia found that 62.1% of nurses experienced workplace violence, with a significant proportion facing physical violence, verbal abuse, and sexual harassment. [16] Similarly, a multi-country study across five European nations revealed that a large number of nurses had been physically attacked or verbally abused at work, primarily by patients and their relatives. [22] These findings underscore the widespread nature of this public health problem and the need for comprehensive research to address it.

Understanding the prevalence, patterns, and determinants of workplace violence against nurses is crucial for developing targeted interventions and policies to prevent and mitigate this issue. Existing studies have identified various factors that contribute to violence against nurses, such as patient aggression, inadequate staffing, poor communication, and urban-rural disparities. [23] By examining these determinants in the Nigerian context, the proposed study will provide valuable insights that can inform the development of evidence-based strategies and policies to address workplace violence against nurses effectively.

While the issue of workplace violence against nurses has been documented in various settings, there is a need for more comprehensive research in the Nigerian context. This study will contribute to the existing body of knowledge on this topic, serving as a reference point for future research and interventions. Additionally, the findings of this study will help raise awareness among policymakers, healthcare administrators, and the general public about the high prevalence

of workplace violence against nurses in Nigeria, thereby prompting the necessary actions to address this pressing issue.

The consequences of workplace violence against nurses are profound, impacting the physical and emotional well-being of healthcare workers. Studies have shown that nurses who experience workplace violence are at risk of physical and psychological harm, including post-traumatic stress disorder, anxiety, depression, burnout, and decreased job satisfaction.[23] Addressing the consequences of violence is essential for ensuring the mental and physical well-being of nurses and maintaining a conducive work environment, which ultimately benefits the healthcare system and patient outcomes.

1.4 RESEARCH QUESTIONS

- What is the prevalence of violence against nurses at UBTH?
- What are the patterns of violence occurring against nurses at UBTH?
- What are the factors influencing violence against nurses at UBTH?
- What are the measures taken to curb violence against nurses at UBTH?
- How effective are the methods taken to curb violence against nurses?

1.5 AIM AND OBJECTIVES

1.5.1 GENERAL OBJECTIVE

To identify the prevalence, pattern and determinants of workplace violence against nurses in the University of Benin Teaching Hospital with a view to provide data for appropriate policy formulation to promote a better workplace atmosphere.

1.5.2 SPECIFIC OBJECTIVES

1. To determine the prevalence of workplace violence against nurses in the University of Benin Teaching Hospital.

2. To determine the pattern of workplace violence done against nurses in the University of Benin Teaching Hospital.

3. To identify the determinants of workplace violence against Nurses in the University of Benin Teaching Hospital.

4. To ascertain the measures taken to curb workplace violence against Nurses in the University of Benin Teaching Hospital.

CHAPTER TWO

LITERATURE REVIEW

2.1 PREAMBLE

This area helped to review other literature available on workplace violence against nurses. This study focused on identifying the prevalence, patterns and determinants of violence against nurses in this study. A conceptual analysis on violence against nurses in the workplace carried out by patients and/or patient relatives gave clarity to the occurrence and provided more information on the determinant factors. Data from this study may help increase the possibility of providing better aid in protecting against acts of violence through administrative and educational interventions as well as environmental and security measures.[24]

2.2 PREVALENCE OF VIOLENCE AGAINST NURSES

A descriptive cross-sectional study was conducted in 2019 on 555 purposively chosen registered nurses and analysed using logistic regression in tertiary hospitals in Northern Thailand. The survey tool used for the study was adapted from the standardised Workplace Violence Questionnaire that was developed by the International Labour Office/International Council of Nurses/World Health Organisation/Public Services International (ILO/ICN/WHO/PSI) in 2003. Results showed that physical workplace violence in the preceding 12 months was 12.1%, while the prevalence of verbal abuse was 50.3%. This survey was just for Northern Thailand however, and so may not represent the prevalence rates of the entire country. [20]

Also, a systematic search was conducted across Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO (a database of abstracts of literature in the field of psychology, produced by the American Psychological Association), Medical Literature Analysis and

Retrieval System Online (MEDLINE), and Scopus (a scientific abstract and citation database, launched by the academic publisher Elsevier), to identify studies on violence against nurses in Africa, published from 2000 to October 2023 was done in 2024. This review included 27 studies and had 9831 nurses involved. The results showed that the pooled prevalence of workplace violence was 62.3%, with verbal abuse emerging as the most prevalent at a prevalence rate of 51.2% with threats and bullying following closely at 23.3% and 22.9% respectively. This review's large study size is significant, as it implies that there is a noteworthy prevalence of violence against nurses within Africa.[25]

A descriptive cross-sectional study to determine the prevalence of workplace violence against nurses was done in 2018 among 200 nurses across the outpatient clinics of 4 Menoufia Governorate Hospitals in Egypt using a multistage random selection. Results showed that 79.0% of them were exposed to workplace violence.[26] This further buttresses the high prevalence rate of workplace violence against nurses in Africa.

Similarly, an institution-based cross-sectional study design was used to study 385 nurses at the University of Gondar Hospital, Ethiopia, in 2019 to assess the prevalence and form of workplace violence against professional nurses. A stratified random sampling technique was used and the result showed that 51.4% (198) of the participants had been victims of violence at their workplace.[27]

Another descriptive cross-sectional study was done in 2019, in Osun state, Nigeria, among 200 consenting nurses in the Clinical Services division of three selected hospitals, to assess their level of awareness and experience of workplace violence, via self-administered questionnaires. The responses of all 200 were returned and analysed. Results showed that 66% of them had

experienced workplace violence with more than half (86%) of all violent incidents occurring at the Emergency and Out-patient department and especially during the night shifts. Verbal abuse (55%) was the most prevalent while sexual harassment (6%) was the least.[11]

In addition, a descriptive cross-sectional study was done among healthcare workers at the University of Nigeria Teaching Hospital Enugu State, in 2018 using a pretested self-administered questionnaire adapted from Workplace Violence in the Health Sector Country Case Study Questionnaire. The proportionate sampling method was used and 412 respondents were selected for the study. Data were analysed using the SPSS version 23 and the Chi-square test of significance with the P value set at 0.05. Results showed that the prevalence of psychological abuse among the participants was 49.7%.[28]

2.3 PATTERN OF VIOLENCE AGAINST NURSES

A Systematic Review and Meta-Analysis was done in China in 2020 to obtain a Quantitative synthesised one-year prevalence of workplace physical violence against health care professionals perpetrated by patients and visitors. A total of 61,800 health care professionals were included in this meta-analysis. The result of the study showed that among all types of violence, nurses face verbal abuse and physical abuse the most.[29]

A descriptive study on Workplace violence towards nurses in Hong Kong: prevalence and correlates, was done in 2017. The study estimated the prevalence and examined the socio-economic and psychological correlates of workplace violence (WPV) among professional nurses in Hong Kong. The study used a cross-sectional survey design. Multivariate logistic regression examines the weighted prevalence rates of WPV and its associated factors for a population of nurses. A total of 850 nurses participated in the study. 44.6% had experienced WPV in the

preceding year. Male nurses reported more WPV than their female counterparts. The most common forms of WPV were verbal abuse/bullying (39.2%), then physical assault (22.7%) and sexual harassment (1.1%).[30]

In addition, a cross-sectional multicentre study carried out in Saudi Arabia in 2022. The multicentre descriptive online survey was conducted using a standardized self-administered questionnaire. Emergency nurses working in public hospitals in the country were invited to participate. Data were analysed with descriptive statistics and multivariate logistic regression. The study recruited 849 emergency nurses. The results revealed that most (73.7%) had experienced WPV in the past two years; 47.4% experienced physical violence and 94.3% experienced non-physical violence. Most exposures to WPV occurred during the afternoon shifts (70.8%), and mainly perpetrated by family members or relatives of the patients (88.3%).[31]

Another study was carried out in Ogun State, Nigeria, on the Prevalence and Pattern of Workplace Violence among Nurses and Other Hospital Personals in Two Selected Hospitals in Ogun State.

The purpose of this study was to look into the prevalence and patterns of workplace violence exposure and its reported impacts between Nurses and other health practitioners in few but major health-care settings in Ogun State, Nigeria. A quantitative research design was used in the study. A random sampling technique was also employed. A total of 372 completed questionnaires out of 1000 were returned after consistent persuasion. The survey revealed that, on average, 41%–45% of nurses suffer workplace violence on a regular basis from senior colleagues, doctors, other health professionals, and outsiders. This ratio suggests that one in three nurses experience violent attacks at work on a regular basis. The most frequent kind of violence faced by nurses was

undermining work owing to an unmanageable and unhealthy workload, which was followed by verbal abuse and constant criticism. The study type used was not included.[32]

Furthermore, a descriptive study on the pattern of workplace violence and perceived effects on nurses' work productivity was done in selected hospitals in Ibadan, Oyo State in 2019. The study was designed to investigate the pattern and perceived effects of WPV on nurses' work productivity in two selected hospitals in Ibadan. This descriptive study was conducted in two purposively selected hospitals. Out of 1,418 nurses, 349 proportional samples were taken and respondents were selected using convenience sampling technique. Two validated questionnaires were used. Data were analysed using frequencies and percentages. Hypotheses were tested using chi-square at $\alpha = 0.05$. Respondents' age was 39±6.5 years; 46.8% were registered nurses, of which 48.1% had worked for 11-20 years. On the pattern of violence, 49 (15.6%) experienced physical violence without a weapon, 39 (12.4%) experienced verbal harassment and bullying. Attackers of 33 (10.5%) were patient relatives.[19]

2.4 DETERMINANTS OF VIOLENCE AGAINST NURSES

A qualitative study was conducted in 2020 in seven emergency departments (EDs) across India to assess the determining factors for violence against healthcare providers. Semi-structured interviews were used, with 63 participants, including 11 attending physicians, 36 resident physicians, 10 nurses, and 5 paramedics, at these seven EDs. The study utilised a semi-structured interview guide developed based on prior research and approved by the George Washington University Institutional Review Board. Results showed that the major causes of violence included financial issues (13.2%), health literacy (23.6%), communication challenges (11.7%),

emotional factors (10.6%), gender factors (3.8%), perpetuation based on media/prior events (1.3%), age factors (4.5%), and drug intoxication (3.4%).[33]

A cross-sectional study was conducted from 2017 to 2018 to determine the factors associated with workplace violence against nurses in three university-affiliated public hospitals in Shiraz, southern Iran—Faghihi, Nemazee, and Rajaei Hospitals. The study sample size of 420 was calculated based on an assumed violence prevalence of 70%, with a maximum acceptable error of 5%, a confidence interval of 95%, and a design effect of 1.3. A multi-stage random sampling method was used to select nurses from various units and wards, considering the proportion of nurses in each hospital and their respective shifts. Results showed that factors triggering violence included unrealistic expectations from patients' companions, non-observance of hospital rules, and requests for cigarettes, narcotics, or alcohol. Long working hours, staff exhaustion, inadequate staffing, and insufficient equipment were identified as significant hospital-related factors contributing to violence.[34]

Another cross-sectional study was conducted in a large, urban, tertiary university medical centre with nearly 700 beds, employing approximately 5,000 persons, including 750 physicians and around 1,000 nurses. The hospital provides advanced medical services, community health programs, and outpatient clinics, with an estimated 30,000 daily visitors to holistically assess the factors leading to violent events in hospitals. The study combined both qualitative and quantitative components, including in-depth interviews with victims and perpetrators, four focus-group discussions, and a self-administered survey. This multi-faceted approach enhanced the trustworthiness of the findings through triangulation of evidence.

Results showed that the major categories from which violence erupted from were: Staff Behaviour (dismissive attitude, arrogance, superiority, disrespect, blunt tone, extreme and violent reactions, lack of guidance, and misalignment of expectations were reported by 1,576 (38.9%) respondents); Patient Behaviour (cultural factors, violent attitudes, sickness, anxiety, loss, drug/alcohol/medication influence, psychiatric conditions, and feelings of fear and loss were noted by 1,076 (26.5%) respondents); Hospital Setting and Organisational Conditions (uncomfortable physical conditions, lack of staffing, lack of transparency, lack of support for staff, and architectural design issues were cited by 704 (17.3%) respondents); Waiting Times (delays in examinations, treatments, physician consultations, and imaging were mentioned by 384 (9.5%) respondents); Dealing with and Resolving a Violent Event (strategies for managing violent incidents were discussed by 128 (3.1%) respondents) and others (personal and other stories of violent episodes were shared by 179 (4.3%) respondents).[35]

Similarly, a hospital-based cross-sectional study was conducted from April 1 to 30, 2015, in three public referral hospitals in Amhara regional state, Ethiopia: University of Gondar Teaching and Referral Hospital, Felege Hiwot Referral Hospital, and Debre Berhan Referral Hospital. Systematic random sampling was employed to select participants, who were then asked about their workplace violence experiences over the past 12 months. Data were collected via a self-administered questionnaire adapted from 428 study participants.

Results indicated that out of 428 study participants, 386 nurses responded, with independent predictors/causes of workplace violence: being patients aged 18-39, small number of staff during the same shift, working in a male ward, having a history of workplace violence, being single and being separated/widowed. These factors were suggestive of being independent predictors of workplace violence among the nurses studied.[36]

Finally, a quantitative cross-sectional descriptive study was conducted to identify risk factors for workplace violence against nurses working at public secondary and tertiary levels of care facilities in Anambra State, Nigeria, in 2023. The study involved a multi-stage sampling technique to select five healthcare facilities and a sample size of 292 nurses. Data collection was carried out using a research instrument adapted from the World Health Organization (WHO) standardised questionnaire on workplace violence.

Results revealed several risk factors for violence against nurses, ranked by prevalence include: Staff shortage (24.38%), Prolonged waiting time for patients (24.38%), Patient negligence by doctors (11.3%), Death of a patient (4.2%), Patient/patient's relative misconduct (3.88%), Discharge against medical advice (0.35%), Misplaced aggression (0.35%). Other factors included Poor facility management/Lack of drugs/equipment, Unaffordability of patient bill, too much workload, misunderstanding from patient's relative, Lack of patience and delay in admitting patients, Failure to carry patient's relative along in patient care, Misconceptions about nurses.[37]

2.5 MEASURES TAKEN TO CURB VIOLENCE AGAINST NURSES

A descriptive study design on the measures to deal with workplace violence against nurses was conducted using self-administered questionnaires in three hospitals located in Amman, the capital city of Jordan, Egypt in 2017. The study included a sample of 107 participants who provided insights into various strategies implemented to mitigate workplace violence.

The findings revealed that only 4.7% of the participants reported the absence of all these measures in their workplace. Specifically, 57% of the participants highlighted the presence of security measures, 35.5% reported improvements in surroundings, 16.8% noted restrictions on

public access, 23.4% mentioned patient screening, and 28% referred to patient protocols. Additionally, 19.6% acknowledged an increase in staff numbers, 23.4% observed changes in shifts or rotation, 17.8% reported reduced periods of working alone, 20.6% emphasised the importance of training, and 12.1% pointed out investment in human resource development.[38]

A Systematic review done in 2021 in the United States to show the Effectiveness of Interventions to De-escalate Workplace Violence against Nurses in Healthcare Settings The studies included in this review all took different approaches to combat workplace violence. However, the approaches could be grouped into three categories based on the scope of the intervention. Some studies provided standalone training, such as awareness workshops. Others offered more structured education programs, such as multi week training involving practical communication skills and role-playing scenarios. Finally, the interventions falling into the third category offered multi component solutions.[6]

Another systematic review was done in India in 2022 on Interventions for workplace violence against health-care professionals. A total of 17 studies were identified based on prevention and management of workplace violence. The results showed that the interventions were mainly educational in nature based on a workshop format. These interventions were found to be effective in improving the perceived ability to deal with situations that lead to violence.[39]

In 2019, a descriptive cross-sectional study was carried out to determine the prevalence of workplace violence among nurses in General Hospitals, Osun State, Nigeria. The study showed that there was workplace violence among nurses in General Hospitals in Osun State, Nigeria. The violence was both verbal and physical. Recommendations given were that there be increased

public enlightenment and education on workplace violence among health workers and the public just as nurses are to be trained on client relationships.[11]

CHAPTER THREE

METHODOLOGY

3.1 STUDY AREA

This study was carried out among nurses in the University of Benin Teaching Hospital, Benin City, Edo State. Edo State is one of the 36 states in Nigeria. It has 18 local government areas and is located in the South-South geopolitical zone of Nigeria. Edo State was initially established as the Mid-Western Region in 1963, carved from the former Western Region of Nigeria. With Benin City as its capital, the region was later renamed Bendel State in 1976.Bendel State was divided on August 27, 1991, creating the present-day Edo and Delta States.[40]

The state lies geographically between latitudes 6°23'55"N to 6°27'39"N and longitude 5°36'18"E to 5°44'18"E and is bounded by the states of Kogi to the northeast and east, Anambra to the east, Delta to the southeast and south, and Ondo to the west and northwest; the Niger River flows along the state's eastern boundary. Benin City is the state capital and largest urban centre.[41] It had a population of 3,233,366 as at the 2006 census and a projected population of 4,857,834 as of 2024 at a growth rate of 2.5%.[42]

The state consists of closely related ethnic groups including Benin, Esan, Etsako, Owan and other smaller tribes, as well as a pool of other tribes who reside in the state. Benin City, an ancient metropolis is the capital and seat of government of Edo State and consists of three Local Government Areas which includes Egor, Oredo and Ikpoba Okha. The predominant occupations in Edo State are Civil Service, artisans and agricultural practice.

University of Benin Teaching Hospital (UBTH) is a multi-specialty healthcare service provider in West Africa. The hospital is located in Ugbowo, Benin City and was established on May 12, 1973 following the enactment of an edict (number 12) of the Nigeria National Health Act.

As the sixth of the 1st generation Teaching Hospitals in Nigeria, its establishment was to complement her sister institution, University of Benin, and to provide secondary and tertiary care to the then Mid-western Region (now Edo and Delta State) and its environs. It provides facilities for the training of a high- and middle-level workforce for the health industry. UBTH spearheads research opportunities for lecturers in the University and others who study the burden of economic morbidity as well as other research issues.[43]

Through the Comprehensive Health Centres in Ogbona and Udo, and the General Practice Clinic that came on stream later, UBTH equally provides some avenues for primary health care to the immediate communities.[44]

University of Benin Teaching Hospital offers an internship and residency training as well as employment opportunities for medical professionals from various medical fields such as Medicine, Pharmacy, Physiotherapy, Ophthalmology, Medical Laboratory scientist, Nursing, Radiography, Dentistry, Nutrition and Dietetics, amongst other professions.[45,46] The nurses form an integral part of the workforce of the University of Benin Teaching Hospital, with nurses working across various hospital specialties, wards and settings. The head of the nursing team in UBTH is designated 'Deputy Director of Nursing Services (DDNS)', with other cadres on the ladder being 'Assistant Director of Nursing Services (ADNS)', 'Chief Nursing Officer (CNO)', 'Assistant Chief Nursing Officer (ACNO)', 'Principal Nursing Officer/Senior Nursing Officer (PNO'/'SNO)', 'Nursing Officer I (NO I)', 'Nursing Officer II (NO II)', and the Intern nurses.

The facility remains one of the foremost institutions in the country reputed for training of high and middle manpower as well as pioneer paramedics and other personnel who attend to presently over 510 patients in various wards and over 910 bed spaces.[47]

3.2 STUDY DESIGN

A descriptive cross-sectional study design was employed to assess the prevalence, patterns and determinants of violence against nurses in the University of Benin Teaching Hospital, Benin City, Edo State, and to ascertain the measures taken to curb violence and improve their health and safety.

3.3 STUDY POPULATION

The study was carried out among nurses in the University of Benin Teaching Hospital, Benin City, Edo State.

3.4 SELECTION CRITERIA

3.4.1 INCLUSION CRITERIA

1. Registered Nurses who work in the University of Benin Teaching Hospital at least 3 months prior to the onset of the study.

11. Those present at the time of data collection.

III. Nurses who gave consent to the study

3.4.2 EXCLUSION CRITERIA

1. Nurses who were unwell at the time of the study

11. Nurses who had not worked up to one month in UBTH since the onset of the study.

3.5 STUDY DURATION

The study was conducted over a period of one year, from September, 2023 to September, 2024.

The timeline was as follows (figure 3 in the Appendix illustrates the workplan):

- Conceptualization and initial write-up: September to December, 2023
- Materials and Methods: January to May, 2024
- Ethical Approval: May to July, 2024
- Data Collection and Results: July to September, 2024
- Discussion and Conclusion: September, 2024

3.6 SAMPLE SIZE DETERMINATION

This was calculated using Cochran's formula for descriptive study.[48]

$n = [(z^2pq)/d^2] \times 1.5$

Where,

1.5 = design effect

n = minimum sample size

z = standard normal deviation

p = prevalence or proportion of population with characteristic of interest

q = 1 – p

d = degree of precision desired.

z = Standard normal set at 1.96 (at 95% confidence interval)

p = 84.2% (the proportion in a study done in 2019, to explore the prevalence of verbal and physical workplace violence against nurses in psychiatric hospitals and to examine its independent socio-demographic correlates in China)[49]

q = 1-0.66 = 0.34

d = degree of precision desired set at 0.05

Substituting the above in the equation

$n = [(1.96)^2 \times (0.84)\ (0.16)]/(0.05)^2] \times 1.5$

n = 309.79

n = 310

To make room for non-response, 10% non-response rate was added to the minimum sample size, utilising the formula for non-response rate.

nf = n/(1– nr)

n = Minimum sample size = 310

nr = Non-response rate = 10% = 0.10

nf = Final Minimum sample size

nf = 310/(1 – 0.10)

nf = 310/0.90 = 344

Thus, the minimum sample size used for this study was **344**.

3.7 SAMPLING TECHNIQUE

The respondents were selected using the stratified sampling method across all the wards, theatres and clinics in the hospital. Employing the stratified sampling technique, a proportionate allocation was used to select nurses from each stratum. The strata were identified as "ward nurses", "clinic nurses" and "theatre nurses".

The total number of nurses in UBTH as at the time of the study was **702**, and this was obtained from the office of the Head of Department of Nursing, UBTH. comprising:

Ward nurses: 509

Clinic nurses: 150

Theatre nurses: 43

Sampling fraction = n/N

Where:

n = sample size = 344

N = total population = 702

Therefore, sampling fraction = 344/702 = 0.490 ≈ 0.49

The sample size of each stratum was calculated using the formula:

Sample size = Sampling fraction × Population of nurses in each stratum

Proportional allocation of nurses:

Ward nurses = 0.49 × 509 = 249.41 ≈ 250

Clinic nurses = 0.49 × 150 = 73.50 ≈ 74

Theatre nurses = 0.49 × 43 = 21.07 ≈ 22

Total, **346**. Therefore, a sample size of 346 was used for the study.

To pick the respondents, simple random sampling technique through balloting was used, and this was done in the various stratum until the required sample size for every strata was reached.

3.8 DATA MANAGEMENT

3.8.1 DATA COLLECTION TOOL

The tool that was used for the survey was a structured self-administered questionnaire. This questionnaire was modified by the researchers using information from literature reviews and questionnaires of previous studies on Prevalence, Patterns and Determinants of Workplace Violence Against Nurses. [50,51] The questions on each section consisted of open and closed questions. The questionnaire was divided into 4 sections as follows:

Section A: Socio-demographic characteristics of the respondents.

This section sought answers to respondents' age, sex, marital status, religion, educational attainment, unit/department/ward, position/grade, number of years practised in profession, and ethnicity.

Section B: Prevalence of workplace violence

The components of the prevalence section included the respondents experience of workplace violence, the frequency of their experience of workplace violence, knowledge of other nurses who had experienced workplace violence, frequency of workplace violence against other nurses, and frequency of experience of specific patterns of violence (verbal abuse, physical assault with weapon, physical assault without weapon, sexual harassment).

Section C: Patterns of workplace violence

The section addressing patterns of workplace violence sought to identify the different forms of workplace violence, who carried them out, where the various forms of violence were carried out, and what time of the day they occurred.

Section D: Determinants of workplace violence

The section on determinants of workplace violence sought to identify the different determinants of workplace violence. It included questions on whether the unrealistic expectations of patients and their relatives, inappropriate knowledge about the disease/health condition, poor communication skills, lack of resources, overcrowding, long waiting time, and inadequate security arrangements, among others, were considered to be determinants by the respondents.

Section E: Measures to curb workplace violence

The section on measures to curb workplace violence focused on identifying and assessing the measures to curb workplace violence that had been employed in UBTH. These measures included controlling the number of visitors within the hospital, educating patients and their relatives about the limitations of the system, regular training of the health care workers on soft skills like communication, and the effectiveness of such measures.

3.8.2 METHODS OF DATA COLLECTION

The questionnaires were numbered and administered. Questionnaires were collected from the respondents either on the same day of administration or not more than two days after.

3.8.3 PRE-TESTING

The questionnaire was pretested among nurses in the Edo Specialist Hospital, Sapele road, Benin City, Edo State. Ten (10%) of the sample size (35 questionnaires) was used for pretesting. This

helped to validate the questionnaire, identify errors and helped point out corrections that were effected in the final questionnaire before it was used.

3.8.4 DATA ANALYSIS

Data obtained was sorted and screened for completeness after which they were coded and entered into the IBM SPSS version 25 spreadsheet for analysis.

Univariate analysis was carried out on sociodemographic and socio-economic data of respondents, as well as on the prevalence, patterns, determinants and factors affecting workplace violence against nurses in UBTH and presented as frequencies and percentages.

Bivariate analysis was also carried out for parametric and non-parametric data. The association between sociodemographic and socioeconomic characteristic of respondents and the overall prevalence of workplace violence against nurses were analyzed.

SCORING SYSTEM ON PREVALENCE

Prevalence of workplace violence was assessed using 8 questions. A correct response was assigned a score of 1 and an incorrect response was assigned a score of 0. Cumulative scores were obtained from the addition of answers. The maximum score was 8 while the minimum score was 0. The scores were converted to percentages and classified:

Low prevalence: $< 50\%$

High prevalence: $\geq 50\%$

3.8.5 DATA PRESENTATION

Results were presented in prose, frequency tables, and charts.

3.9 ETHICAL CONSIDERATIONS

Approval to carry out the study was obtained from the Ethics and Research Committee of the University of Benin Teaching Hospital.

A cover letter was obtained from the Department of Community Health, University of Benin. Ethical approval with protocol number ADM/E 22/A/VOL. VII/148654878 was obtained from the Health Research Committee (HREC), University of Benin Teaching Hospital.

Permission was taken from the ward managers of the various wards and informed consent was taken from participants concerning their decision. Respondents were assured that their participation was voluntary, and their responses were to be treated with confidentiality.

3.10 LIMITATIONS TO THE STUDY

The information obtained was based on self-reporting and for that reason, was susceptible to recall bias. Other limitations included unavailability of respondents due to the hectic schedule in the hospital, unwillingness of respondents, and the absence of some nurses due to rotational shifts.

CHAPTER FOUR

RESULTS

Three hundred and forty-six (346) respondents participated in the study. The results were divided into sections as follows:

Section A: Socio-demographic characteristics of respondents

Section B: Prevalence of Workplace Violence among Respondents

Section C: Patterns of Workplace Violence among Respondents

Section D: Determinants of Workplace Violence among Respondents

Section E: Measures Taken to Curb Workplace Violence among Respondents

SECTION A

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Table 1: Socio-demographic Characteristics of Respondents

Variable	Frequency (n = 346)	Percent
Age Group (Years)		
20-29	103	29.8
30-39	92	26.6
40-49	76	22.0
50-59	75	21.7
Mean ± SD (37.7±10.9)		
Sex		
Female	290	83.8
Male	56	16.2
Marital Status		
Married	210	60.7
Single	106	30.6
Widowed	26	7.5
Divorced	4	1.2
Religion		
Christianity	331	95.7
Islam	14	4.0
Atheism	1	0.3
Tribe		
Benin	133	38.4
Igbo	102	29.5
Yoruba	30	8.7
Esan	21	6.1
Etsako	19	5.5
Urhobo	16	4.6
Owan	10	2.9
Hausa	7	2.0
Ibibio	5	1.4
Igbanke	2	0.6
Ebira	1	0.3

A higher proportion, 103 (29.8%) of the respondents fell within the age group of 20-29 years with a mean age of 37.7±10.9 years. Majority of the respondents, 290 (83.8%) were female and more than half, 210 (60.7%), were married. Most respondents, 331 (95.7%), practiced Christianity as their religion and the most represented tribe, 133 (38.4%) was Benin.

Table 2: Socio-economic Characteristics of Respondents

Variable	Frequency (n = 346)	Percent
Highest Degree		
BNSC	252	72.8
RN/RM	32	9.2
HND	30	8.7
MSC	12	3.5
RN	7	2.0
Diploma	4	1.2
RN/Diploma	3	0.9
RN/EN	3	0.9
BLS/HND	1	0.3
OND	1	0.3
PGDE	1	0.3
Years of Experience		
<10	201	58.1
10-20	98	28.3
>20	47	13.6
Designation		
DDNS	6	1.7
ADNS	22	6.4
CNO	86	24.8
ACNO	45	13.0
PNO/SNO	63	18.2
NOI	32	9.2
NOII	18	5.2
Intern	75	21.7

Majority, 252 (72.8%), of the respondents had BNSC as their highest attained qualification. More than half of them, 201 (58.1%) had less than 10 years of working experience. The most represented positions of nurses were CNOs and Interns, with 86 (24.8%) and 75 (21.7%) respectively.

Table 3: Unit of Respondents (Wards)

Unit	Frequency (n = 248)	Percent
Triage	36	14.5
Female Medical Ward	25	10.1
Surgical Ward	22	8.9
Neurosurgery Ward	17	6.9
Orthopaedics Ward	17	6.9
Oncology Ward	16	6.5
Male Medical Ward	15	6.0
Medical Emergency Room	11	4.4
Paediatrics Ward	10	4.0
Burns And Plastics Ward	9	3.6
Psychiatry Ward	9	3.6
Gynaecological Ward	8	3.2
Labour Ward	8	3.2
Geriatric Ward	6	2.4
Maternity Ward	6	2.4
Ophthalmic Ward	6	2.4
Trauma Ward	6	2.4
Surgical Emergency Room	5	2.0
Special Care Baby Unit	4	1.6
Children Emergency Room	3	1.2
Renal Unit	3	1.2
Intensive Care Unit	3	1.2
Trauma Ward	1	0.4
Maternity Ward 2	1	0.4
Neurological Ward	1	0.4

This table highlights the respondents in the wards. The highest represented ward was the Triage, 36 (14.5%), and the least represented were the Trauma ward, Maternity Ward 2 and Neurological ward with 1 respondent each (0.4%).

Table 4: Unit of Respondents (Clinics and Theatre)

Unit	Frequency	Percent
Clinic (n = 76)		
Antenatal Clinic	23	28.9
Surgical Out-patients Department Clinic	7	9.2
Post-natal Clinic	7	9.2
Centre for Disease Control and Prevention Clinic	5	6.6
Consultant Out-patient Department Clinic	5	6.6
Human Reproduction Research Program Clinic	4	5.3
Orthopaedics Clinic	4	5.3
General Practice Clinic	3	3.9
Nursing Services	3	3.9
Opthalmology Clinic	3	3.9
Neurosurgery Clinic	2	2.6
National Health Insurance Scheme Clinic	2	2.6
Radiology Unit	2	2.6
Dermatology Clinic	1	1.3
Directly Observed Therapy Short-course Clinic	1	1.3
Ear, Nose, Throat, Head and Neck Clinic	1	1.3
Orthopaedics Clinic	1	1.3
Paediatrics Clinic	1	1.3
Special Investigations Unit	1	1.3
Theatre (n = 22)	22	100.0

This table highlights the respondents in the clinics and theatre. The highest represented clinic was the Antenatal Clinic, 23 (28.9%), and the respondents who worked at the theatres were 22.

SECTION B

PREVALENCE OF WORKPLACE VIOLENCE AMONG RESPONDENTS

Table 5: Prevalence of Workplace Violence Among Respondents

Variable	Frequency	Percent
Ever experienced workplace violence (n = 346)		
Yes	270	77.6
No	78	22.4
Experienced workplace violence in the past twelve months (n = 270)		
Yes	194	71.9
No	76	28.1
Frequency of experience (n = 346)		
Daily	61	17.6
Weekly	41	11.8
Monthly	83	24.0
Yearly	71	20.5
Never	90	26.0
Knowledge of anyone who experienced workplace violence (n = 346)		
Yes	303	87.6
No	43	12.4

Majority of the respondents, 270 (77.6%) had experienced workplace violence throughout their careers, and 194 (71.9%) reported to have experienced it within the last 12 months. The most recorded frequency of violence among respondents was on a monthly basis, with almost quarter of respondent 83 (24.0%) being victims of workplace violence month. Also, almost all the respondents 303 (87.6%) knew of someone asides themselves who had experienced workplace violence.

Table 6: Prevalence of the Forms of Workplace Violence Among Respondents

Forms of Violence (n = 346)	Daily	Weekly	Monthly	Yearly	Never
			Frequency (%)		
Verbal Altercations	83 (24.0)	55 (15.9)	82 (23.7)	42 (12.1)	84 (24.3)
Assaults without a weapon	35 (10.1)	27 (7.8)	58 (16.8)	46 (13.3)	180 (52.0)
Assaults with a weapon	2 (0.6)	14 (4.0)	34 (9.8)	49 (14.2)	247 (71.4)
Sexual Harassment	4 (1.2)	8 (2.3)	15 (4.3)	25 (7.2)	294 (85.0)

Verbal altercations were the most frequently experienced form of workplace violence, with frequencies being significantly higher than other forms of workplace violence, and its occurrence as follows: daily (24.0%), weekly (15.9%), monthly (23.7%) and yearly (12.1%).

The least experienced form of workplace violence among respondent were assaults with a weapon and sexual harassment. Respondents who had never been victims of assault with a weapon nor sexual harassment were 71.4% and 85.0% respectively.

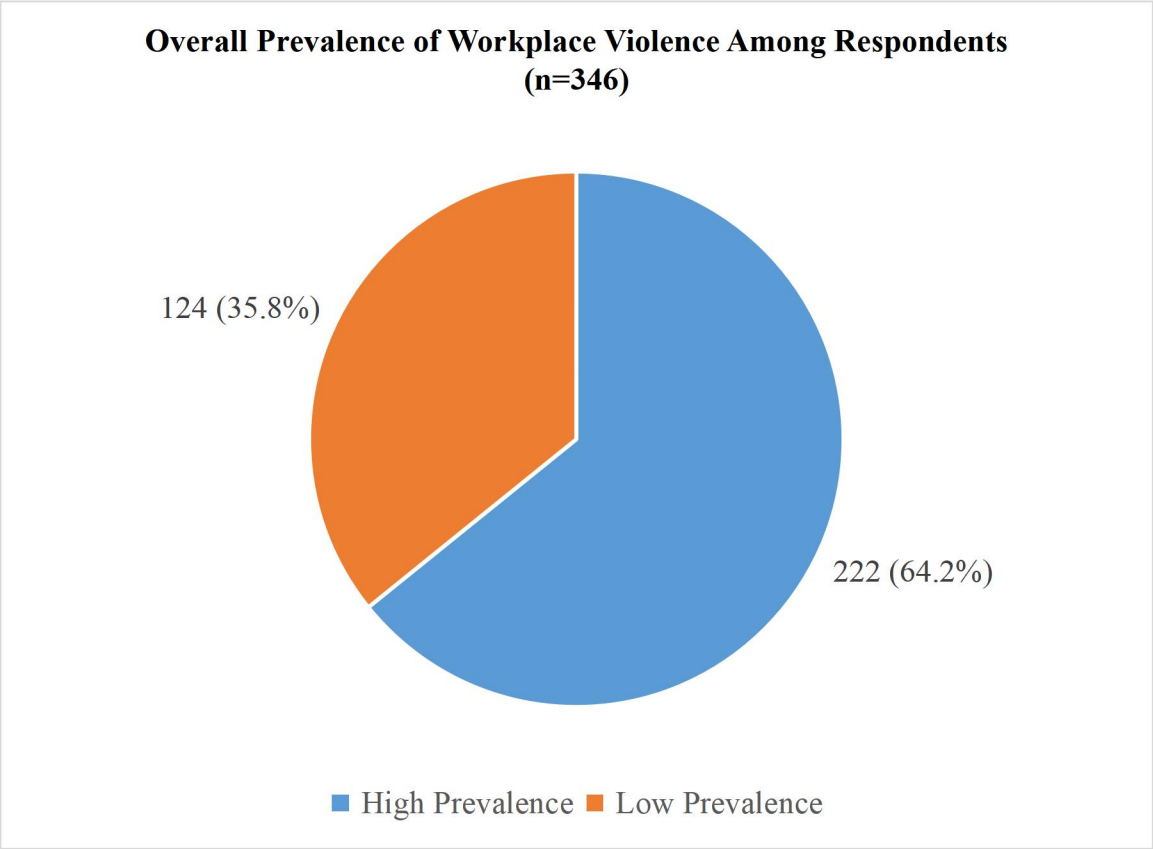

Figure 1: Overall prevalence of workplace violence among respondents

There was overall high prevalence of workplace violence among almost two-third of the respondents, 222 (64.2%); while about one-third of the respondents had overall low prevalence of workplace violence.

Table 7: Sociodemographic Characteristics and Overall Prevalence of Workplace Violence

Variable	Overall Prevalence		Test statistics	p-value
	High Freq. (%)	Low Freq. (%)		
Age Group (Years)			χ^2 =15.442	
20-29	59 (57.3)	44 (42.7)		
30-39	63 (68.5)	29 (31.5)		
40-49	40 (52.6)	36 (47.4)		
50-59	60 (80.0)	15 (20.0)		
Sex			χ^2 = 1.534	0.228
Female	182 (62.8)	108 (37.2)		
Male	40 (71.4)	16 (28.6)		
Marital Status			#Fisher's exact=13.381	**0.002**
Divorced	4 (100.0)	0 (0.0)		
Widowed	24 (92.3)	2 (7.7)		
Married	131 (62.4)	79 (37.6)		
Single	63 (59.4)	43 (40.6)		
Tribe			#Fisher's exact =2.988	0.384
Hausa	6 (85.7)	1 (14.3)		
Igbo	69 (67.6)	33 (32.4)		
Benin	79 (59.4)	54 (40.6)		
Yoruba	19 (63.3)	11 (36.7)		

Fisher's exact test was used as >20% of expected cell counts were less than 5

This table illustrated sociodemographic characteristics and their relationship with the overall prevalence of workplace violence.

The prevalence of workplace violence varied significantly across age groups (χ^2 = 15.442, p = 0.001). The highest prevalence was observed within the 50-59 age group, where 60 (80.0%) of the respondents in that age group were reported to have an overall high prevalence rate of workplace violence. The overall prevalence decreased with younger age groups, with 40-49 years having a prevalence of 52.6%, 30-39 at 68.5%, and 20-29 at 57.3%. These results

suggested that older individuals, particularly those aged 50-59, were more likely to report experiencing workplace violence.

There was no statistically significant difference in the overall prevalence of workplace violence between sexes (χ^2 = 1.534, p = 0.228). However, more males (71.4%) had a high overall prevalence of workplace violence compared to females (62.8%).

The association between marital status and workplace violence was statistically significant (Fisher's exact = 13.381, p = 0.002). Divorced individuals (100.0%) reported the highest prevalence, followed by widowed individuals (92.3%). Married individuals also had a relatively high prevalence (62.4%), while single individuals had the lowest prevalence (59.4%).

No statistically significant difference was found in the prevalence of workplace violence based on tribe (Fisher's exact= 2.988, p = 0.384). However, the Hausa (85.7%), Igbo (67.6%), and Yoruba (63.3%) groups reported higher overall prevalence compared to the Benin group (59.4%).

Overall, the findings highlighted significant associations between age, marital status, and the overall prevalence of workplace violence, while sex and tribe do not show statistically significant associations.

Table 8: Socio-economic Characteristics and Overall Prevalence of Workplace Violence

Variable	Overall Prevalence		Test Statistics	p-value
	High Freq. (%)	Low Freq. (%)		
Highest Degree			#Fisher's exact=15.224	0.064
BNSC	159 (63.1)	93 (36.9)		
RN/RM	15 (46.9)	17 (53.1)		
HND	25 (83.3)	5 (16.7)		
MSC	9 (75.0)	3 (25.0)		
RN	5 (71.4)	2 (28.6)		
Diploma	3 (75.0)	1 (75.0)		
RN/Diploma	3 (100.0)	0 (0.0)		
RN/EN	2 (66.7)	1 (33.3)		
BLS/HND	0 (0.0)	1 (100.0)		
OND	1 (100.0)	0 (0.0)		
PGDE	1 (100.0)	0 (0.0)		
Years of Experience			#Fisher's exact=17.506	**<0.001**
<10	124 (61.7)	77 (38.3)		
10-20	56 (57.1)	42 (42.9)		
>20	42 (89.4)	5 (10.6)		
Designation			χ^2=3.839	0.805
DDNS	4 (66.7)	2 (33.3)		
ADNS	14 (63.6)	8 (36.4)		
CNO	53 (62.4)	32 (37.6)		
ACNO	33 (73.3)	12 (26.7)		
PNO/SNO	43 (68.3)	20 (31.7)		
NOI	21 (65.6)	11 (34.4)		
NOII	10 (55.6)	8 (44.4)		
Intern	44 (58.7)	31 (41.3)		

Fisher's exact test was used as >20% of expected cell counts were less than 5

This table showed socio-economic characteristics and their relationship with the overall prevalence of workplace violence.

The prevalence of workplace violence did not significantly vary by educational attainment (Fisher's exact = 15.224, p = 0.064). The majority of individuals across different degrees reported a high overall prevalence of workplace violence, with those holding an RN/Diploma, OND and PGDE having a 100% (all reported a high overall prevalence of workplace violence). Individuals with a BNSC degree had a 63.1% high overall prevalence, while those with Diploma and MSC degrees had similar high overall prevalence rates of 75.0%. The HND group had a high overall prevalence of 83.3%, and only the BLS/HND group had no reports of high overall prevalence of workplace violence (0%).

There was a significant association between years of experience and overall prevalence of workplace violence (Fisher's exact = 17.506, p = <0.001). Individuals with more than 20 years of experience reported the highest rate of high overall prevalence (89.4%). Those with fewer than 10 years of experience had a high overall prevalence of 61.7%, while individuals with 10-20 years of experience showed the lowest prevalence (57.1%).

The prevalence of workplace violence across designations did not show a statistically significant difference (χ^2= 3.839, p = 0.805). However, individuals in the ACNO position had the highest overall prevalence rate (73.3%). Other higher-level positions such as DDNS (66.7%), ADNS (63.6%), and CNO (62.4%) reported similar high overall prevalence rates. Those in PNO/SNO, NOI, and NOII had high overall prevalence rates of 68.3%, 65.6% and 55.6% respectively, while the Interns had a high overall prevalence rate of 58.7%.

In summary, while the highest degree and position of the respondents did not significantly influence the overall prevalence of workplace violence, there was a significant relationship between years of experience and the overall prevalence of workplace violence, with those having more years of experience showing higher prevalence rates.

SECTION C

PATTERNS OF WORKPLACE VIOLENCE AMONG RESPONDENTS

Table 9: Patterns of Workplace Violence Experienced Among Respondents

Variable	Frequency (n = 270)	Percent
Who carried out workplace violence observed by respondent*		
Patient relative	264	76.3
Patient	94	27.2
Patient caregiver	74	21.4
Other health workers	40	11.6
Other nurses	28	8.1
Who carried out workplace violence against respondent*		
Patient relative	182	52.6
Patient	65	18.8
Other health workers	49	14.2
Patient caregiver	39	11.3
Other nurses	18	5.2

***Multiple response question**

Patient relatives were the highest perpetrators of both the acts of workplace violence observed by and done against the respondents, accounting for 264 (76.3%) of reported cases of workplace violence that were seen carried out on others and 52.6% of acts of workplace violence experienced by 182 of the respondents themselves.

Table 10: Location of Workplace Violence Experienced Among Respondents

Location*	Frequency (n = 270)	Percent
Emergency ward	184	53.2
Male medical ward	65	18.8
Male psychiatry ward	39	11.3
Female medical ward	38	11.0
Male surgical ward	38	11.0
Female surgical ward	33	9.5
Paediatric ward	26	7.5
Female psychiatry ward	25	7.2
Oncological ward	18	5.2
Maternity ward	17	4.9
Theatre	13	3.8

***Multiple response questions**

Cases of workplace violence were widely distributed among all the indicated departments and wards. However, the emergency ward was where the most acts of workplace violence were noted to have occurred (53.2%), with the male medical ward being the location with the second highest prevalence, as reported by 65 (18.8%) respondents. The least occurrence was recorded in the theatres (3.8%).

Table 11: Time of the Day Workplace Violence was Experienced Among Respondents

Time*	Frequency (n = 270)	Percent
Morning	105	30.3
Afternoon	154	44.5
Evening	126	36.4
Night	145	41.9

***Multiple response questions**

Afternoons were noted to be the highest occurrence for the time of the day when workplace violence occurred, among 154 (44.5%) respondents. This was closely followed by nighttime, which had 145 (41.9%) respondents reporting that they had also experienced workplace violence at this time. Evenings and mornings had 126 (36.4%) and 105 (30.3%) respondents respectively.

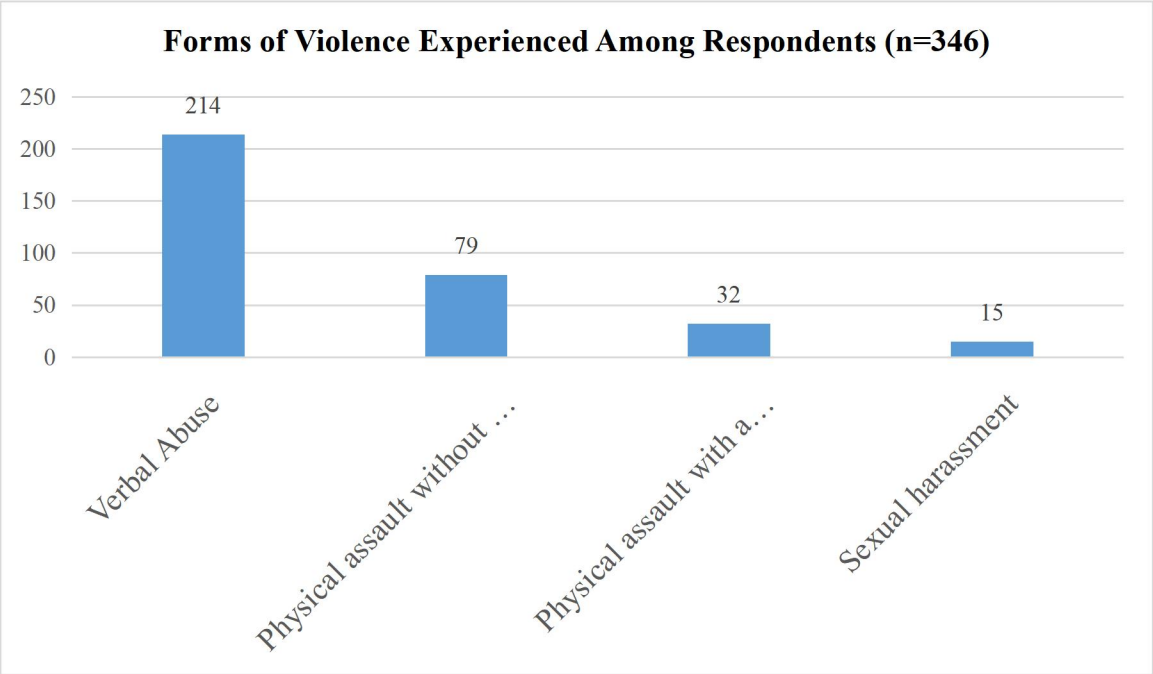

Figure 2: Forms of violence experienced among respondents

Among the 270 respondents, the form of workplace violence most experienced was verbal abuse, 214 (61.8%), then physical assault without a weapon, 79 (22.8%). Physical assault with a weapon and sexual harassment were the least recorded among respondents, at 32 (9.2%) and 15 (4.3%) respectively.

SECTION D

DETERMINANTS OF WORKPLACE VIOLENCE AMONG RESPONDENTS

Table 12: Determinants of Workplace Violence Among Respondents

Determinants (n = 346)	Agree	Indifferent	Disagree
		Frequency (%)	
Unrealistic expectations of patient relatives	324 (93.6)	10 (2.9)	12 (3.5)
Poor communication skills	324 (93.6)	11 (3.2)	11 (3.2)
Long waiting time	315 (91.0)	19 (5.5)	12 (3.5)
Wrong knowledge about disease condition	312 (90.2)	19 (5.5)	15 (4.3)
Lack of resources	309 (89.3)	19 (5.5)	18 (5.2)
Inadequate security arrangement	303 (87.6)	23 (6.6)	20 (5.8)
Lack of provision of harsh punishments	296 (85.5)	26 (7.5)	24 (6.9)
Overcrowding	293 (84.7)	29 (8.4)	24 (6.9)
Higher grades of nurses	184 (53.2)	24 (6.9)	138 (39.9)
Only happens to female nurses	98 (28.3)	29 (8.4)	219 (63.3)
Clinic nurses do not experience WPV	78 (22.5)	23 (6.6)	245 (70.8)

The respondents agreed that the factors that promoted workplace violence included: unrealistic expectations of patient relatives (93.6%), poor communication skills (93.6%), long waiting time (91.0%), wrong knowledge about the disease by patients and their relatives (90.2%), lack of resources (89.3%), inadequate security arrangement (87.6%), lack of provision of harsh punishment against offenders (85.5%), and overcrowding (84.7%).

Most of the respondents 219 (63.3%) however, did not affirm that only female nurses experienced workplace violence. Likewise, 245 (70.8%) of the respondents did not agree with the notion that nurses who worked in the clinics were exempt from experiencing workplace violence.

Table 13: Logistic Regression Model for the Predictors of WPV Against Nurses

Predictors	Coefficient ratio (β)	Odds ratio	95% Confidence Interval		p value
Variable			**Lower**	**Upper**	
Age	0.021	1.021	0.933	1.117	0.652
Sex					
Female*		1			
Male	0.546	1.726	0.865	3.443	0.122
Marital status					
Never married*		1			
Ever married	-0.225	0.986	0.482	2.017	0.969
Years of experience					
<10*		1			
10-20	-0.103	0.902	0.418	1.944	0.792
>20	2.153	8.614	2.054	36.135	**0.003**

**R^2= 12.0-16.4%, ***Reference variable.

As age increased, the likelihood of respondents having a high overall prevalence was 1.021 (p = 0.652, 95% CI = 0.933-1.117). The male respondents were more likely to have a high overall prevalence of workplace violence, with odds of 1.726, than female respondents. (p = 0.122, 95% CI = 0.865-3.443). The respondents who had ever married were less likely to have a high overall prevalence, with odds of 0.986, than those who had ever married (p = 0.969, 95% CI = 0.482-2.017). These were not statistically significant.

Years of experience however, was statistically significant, as it was observed that those with greater than 20 years of experience were more likely to have a high overall prevalence, with odds of 8.614, than those with less than 10 years of experience (p=0.003, 95 % CI=2.054-36.135).

SECTION E

MEASURES TAKEN TO CURB WORKPLACE VIOLENCE AMONG RESPONDENTS

Table 14: Measures to Curb Workplace Violence Among Respondents

Variable	Frequency (n = 346)	Percent
Control number of visitors	325	93.9
Strategically positioned security personnel	315	91.0
Educate patients and relatives	310	89.6
Regular soft skill training for healthcare workers	310	89.6
Improving healthcare facilities	308	89.0
Strong legislative measures	308	89.0
Unbiased media reporting	293	84.7
Self-defense training	258	74.6
Appropriate compensation of victims	242	69.9

The respondents indicated that the measures that could be instituted to curb the occurrence of workplace violence in the institution included: controlling number of visitors (93.9%), strategic positioning of security personnels (91.0%), appropriately educating patients and patient relatives (89.6%), regular training of healthcare workers on soft skills (89.6%), improving healthcare facilities (89.0%), strong legislative measures (89.0%), unbiased media reporting (84.7%), self-defense training (74.6%), and appropriate compensation of victimized nurses (69.9%).

CHAPTER FIVE

DISCUSSION

This study was carried out among nurses in a tertiary hospital, and the findings of this study revealed that workplace violence was a common occurrence, with more than two-thirds of the respondents reporting a lifetime prevalence of workplace violence. Most of them also had a high preceding 12-month prevalence, and majority had a high overall prevalence rate. This is quite high as nearly 8 in 10 respondents have experienced workplace violence in their lifetime, and over half in the past year. This brings to the fore the magnitude of this challenge especially as it concerns workers safety. Ensuring a safe work environment is critical in enhancing worker productivity and job satisfaction. Conversely, exposure to violence can lead to anxiety, depression, decreased productivity and even increased rates of absenteeism from work. It was quite disheartening that nurses who provide essential patient care, looking out for the well-being and ensuring the recovery of their patients were exposed to hostilities in the line of their duty. This occurrence may be due to the perceived state of emotional turmoil, stress, anxiety and unsettlement arising in patients or their relatives, due to the realisation of a state of ill-health, thus creating an atmosphere of tension where acts of violence inadvertently or intentionally erupt. These findings are consistent with those from previous studies done in Southeast Asia and Western Pacific regions which showed that the pooled prevalence of workplace violence among nurses in these regions had occurred in more than half of the respondents.[52]

The most common form of violence reported was verbal abuse by more than half of the respondents, and this was significantly higher than other forms of abuse on daily, weekly, monthly, and yearly comparisons. This signifies that verbal abuse is one of the forms that is

easily perpetrated seemingly appearing to have been normalized and considered innocuous however its effects are far from inconspicuous ranging from creating anxiety in workers, depression, decreased self-esteem to chronic stress. Verbal abuse also creates a hostile work environment which could make the work less gratifying. The high prevalence of verbal violence may come from various aspects of the patient's conditions and could range from pain or restlessness, frustration, hallucination, agitation, substance misuse, a history of suicidal behaviour, or an antisocial personality. Assaults without a weapon were also common, with more than a tenth of the respondents experiencing it yearly. However, sexual abuse was the least form carried out. This may be due to the finding that most of the nurses were married, and that could have served as a deterrent to perpetrators from indulging in any forms of sexual harassment. These findings are in line with those from studies done in Ghana and Thailand where verbal abuse was also more prevalent than other forms of workplace violence experienced by nurses.[20,50]

The primary perpetrators of reported incidents were patients' escorts/relatives and even patients themselves, which is similar to findings from a study done in Kenya where most incidents of WPV were also found to be perpetrated by patients and their relatives.[53] Findings from a study done previously however, contrasted slightly with this, as fellow clinical nurses were found to be the most predominant perpetrators, followed by patients and their relatives.[20]

Violence was reported in all units. However, the Emergency Ward was reported by more than half of the respondents to be a location where such incidents occurred. This may be due to the fact that the emergency room is usually the first point of call in most hospital admissions and the patients/their relatives are usually in a state characterized by apprehension, fear and confusion, with volatility of emotions at that time of arrival. This creates intense tension amongst both the

healthcare workers and those seeking care, thus violent outbursts are very common in those settings. This finding corroborates with that from a study done in a tertiary hospital in Israel, where the departments most exposed to violence were the emergency room and outpatient clinics.[35]

Workplace violence was noted in this study to occur at all times of the day, with slight increases in the frequencies during afternoons and at night, with mornings being the least. This may be explained by the assumption that in the mornings, people would be in a relatively calm state compared to later times of the day, when activities would have intensified, giving rise to the presence of other stressors, which could contribute to the expression of violent behaviors. This is in line with findings from a study done in Kenya, where most incidents of physical violence occurred during the afternoon or night shifts.[53]

The findings from this study revealed that factors contributing to prevalence of workplace violence against nurses ranged from unrealistic expectations of patient relatives concerning the treatment their relatives, the patients, receive; poor communication skills on the part of the nurses to adequately explain the realities of patient care; long waiting time by patients or their relatives; wrong knowledge about the disease by patients and/or their relatives; lack of adequate resources to provide optimal care for patients; inadequate security arrangement within the health facilities; lack of provision of harsh punishment against offenders; to overcrowded hospital settings; with unmet expectations being the most significant contributor to workplace violence. This was similar to findings from a study done in Taiwan where violence was caused by patients having insufficient information or misunderstanding the information related to their overall disease, inspection, and treatment results.[54]

The multifaceted nature of these factors thus highlighted the need for a multifactorial approach to address them, with inputs required from both the healthcare workers (nurses) themselves and the management of the healthcare facilities, so as to reduce the rates of future occurrences of violence.

This study also highlighted significant associations between age and the overall prevalence of workplace violence, with increased reports of experiences of workplace violence seen among the older nurses when compared to the younger nurses. Sex and tribe however, did not show significant associations, with both male and female nurses from all represented tribes experiencing acts of workplace violence.

This sharply contrasted with findings from a study done in Northern Thailand where there was a statistically significant correlation between age and physical violence in the inverse direction where, as the age of health workers increased, the violence against them decreased.[20]

In addition, the study also revealed that there was a significant association between the years of experience and overall prevalence of workplace violence, as respondents who had higher years of working experience reported higher overall prevalence rates of workplace violence. Prevalence was highest among those with greater than 20 years of working experience, while individuals with 10-20 years of experience showed the lowest prevalence. This might have been due to the fact that increased work exposure among older nurses predisposed them to being victims of workplace violence, as these older nurses who may have been perceived to be more adept with patient handling, may have been assigned to more difficult patients or patient relatives. This is however not consistent with findings from a study in Northern Thailand where younger nurses with less years of working experience reported more incidents of physical threat or verbal abuse than older nurses.[20] It underscores the need to constantly train and retrain nurses with the

requisite skills on people management, irrespective of their years of experience, to keep conflict prone situations under control. Although it may be thought that these skills would be picked up subconsciously with years of experience, it seems necessary to deliberately institute such training programs and not leave acquisition of the skills to just learning from the exposures alone, thus equipping the workers with the required knowledge and skills on how to douse the atmosphere of violence before it escalates.

Concerning measures to curb workplace violence, this study found out that measures such as controlling number of visitors, strategically positioning security personnel, appropriately educating patients and patient relatives, regular training of healthcare workers on soft skills, improving healthcare facilities, strong legislative measures, unbiased media reporting, self-defense training of healthcare workers, and appropriate compensation of victimized nurses were indicated as likely effective methods. This is commendable as it shows that there is a reasonable level of awareness concerning the measures that can be made or are already in place, to decrease the incidence of workplace violence. However, the continued occurrence of the events of workplace violence demonstrated the need for a heightening of these measures and the introduction of better suited and more effective measures, which would help to significantly reduce the existence of workplace violence and its consequences.

These findings were similar to those obtained from previous studies done in Egypt and China where the workplaces had measures such as security arrangements, improving work surroundings, restricting visitors and public access, patient protocols, and investment in human resource development, via trainings put in place, and consequently had a lower risks of occurrence of physical workplace violence, [38] thus further underscoring the need for such measures to be put in place and highlighting the benefits they would produce if instituted.

CONCLUSION

The prevalence of workplace violence against nurses was high, as majority of the respondents had experienced workplace violence throughout their careers.

The patterns of workplace violence were identified with respect to the type, and the most recognized form, perpetrators, time and location of occurrence were verbal abuse, patient relatives, afternoons, and the emergency ward.

Unrealistic expectations of patient relatives and poor communication skills were reported as the commonest determinants of workplace violence.

Controlling the number of visitors and strategically positioning security personnel were reported as the commonest indicated measures to curb workplace violence.

RECOMMENDATIONS

The study noted a prevalence of workplace violence against nurses, identified the patterns, the significant determinants associated with said prevalence, as well as measures that could help curb this within the University of Benin Teaching Hospital. The results of this study highlight a need for improvement, and for this reason, it is crucial to provide relevant recommendation to appropriate stakeholders in order to curb the prevalence of workplace violence against nurses in the University of Benin Teaching Hospital.

TO THE FEDERAL GOVERNMENT

1. Enact national laws specifically addressing workplace violence in the healthcare sector, with severe penalties for perpetrators.

2. Establish a national reporting system for workplace violence, ensuring accurate data collection and evidence-based policy formulation.

3. Implement nationwide awareness campaigns to educate the public about the impact of workplace violence on healthcare delivery and the legal consequences for offenders.

TO THE HOSPITAL ADMINISTRATORS

1. Employ trained security personnel at strategic points within the hospital and ensure surveillance systems are in place, especially in high-risk areas like emergency and psychiatric departments.

2. Establish and enforce a zero-tolerance policy towards any form of workplace violence, with clear procedures for reporting, investigating, and responding to incidents.

3. Provide regular training sessions on managing aggressive behavior and improving communication skills to help nurse de-escalate potentially violent situations.

4. Allocate funding for improved security systems in university teaching hospitals, including CCTV, trained security personnel, and panic buttons.

TO THE HEADS OF THE VARIOUS NURSING DEPARTMENTS

1. Advocate for the inclusion of workplace violence prevention in hospital safety protocols and ensure nurses are protected by adequate security measures.

2. Ensure that nurses are encouraged to report all incidents of violence without fear of retribution and that such incidents are thoroughly documented.

3. Provide clear communication channels for patient relatives to voice their concerns and complaints without resorting to violence.

TO THE PATIENT RELATIVES

1. Recognize the pressures faced by nurses with respect, even in emotionally charged situations.
2. When expressing concerns or needs, communicate clearly, calmly, and respectfully, avoiding aggressive tones or languages to ensure effective and positive interactions with healthcare professionals.
3. Engage cooperatively with healthcare professionals to support patient care and reduce misunderstandings that could lead to aggression.
4. Be enlightened about legal consequences of violence against healthcare workers, as such behavior is unacceptable and punishable under law.

TO OTHER HEALTH CARE WORKERS

1. Ensure and practice respectful communication between colleagues and other members of the healthcare team.

2. Manage personal and work-related stress adequately to ensure optimal functioning at work.

3. Foster collaborative work by inviting inputs from healthcare team members, and recognize nurse expertise.

4. Engage in constructive conflict-resolution practices, focusing on issues, not persons.

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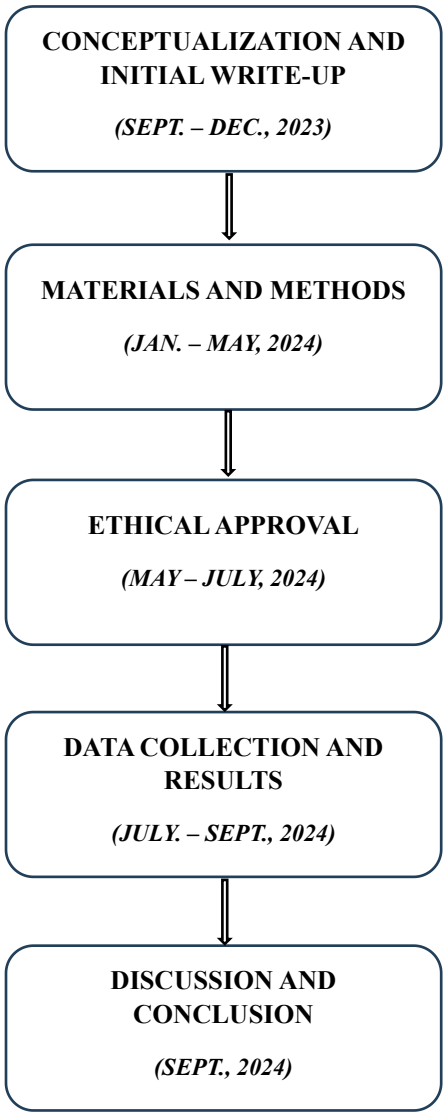
APPENDIX I

WORKPLAN FOR THE STUDY (THE PREVALENCE, PATTERNS, DETERMINANTS OF WORKPLACE VIOLENCE AGAINST NURSES AND MEASURES TAKEN TO CURB THEM IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL)

Figure 3: Workplan flowchart of the study duration



APPENDIX II

QUESTIONNAIRE

THE PREVALENCE, PATTERNS, DETERMINANTS OF WORKPLACE VIOLENCE AGAINST NURSES AND MEASURES TAKEN TO CURB THEM IN THE UNIVERSITY OF BENIN TEACHING HOSPITAL

Dear respondent,

We are final-year medical students currently doing our one-year project to assess the prevalence, patterns and determinants of workplace violence against nurses in the University of Benin Teaching Hospital, and the measures taken to curb them. All information provided will be kept confidential.

PLEASE NOTE: This questionnaire asks about your knowledge and personal experience of workplace violence against nurses. Please kindly answer all questions as accurately as possible. There are no right or wrong answers, and there is no penalty for opting out of the study at any time. Be assured that every information given to us will be treated with utmost confidentiality. DO NOT WRITE YOUR NAME, AS YOUR RESPONSE WILL REMAIN ANONYMOUS, THANK YOU.

DATE: _____

SECTION A: SOCIODEMOGRAPHIC CHARACTERISTICS

INSTRUCTION: Answer all questions correctly. Please tick one answer only

1. Age (in years, as at last birthday): ……..
2. Gender: Male ( ) Female ( )
3. Tribe: Yoruba ( ) Benin ( ) Igbo ( ) Hausa ( ) Other (specify) ……..
4. Highest degree: .....
5. Department/Ward: .....
6. Number of years of experience after completion of degree: .....
7. Position/Grade: DDNS ( ) ADNS ( ) CNO ( ) ACNO ( ) PNO/SNO ( ) NO I ( ) NO II ( ) Intern ( )
8. Marital status: Single ( ) In a relationship ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( )
9. Religion: Christian ( ) Muslim ( ) Traditional African Religion ( ) Other (specify) ……..

SECTION B: PREVALENCE OF WORKPLACE VIOLENCE AGAINST NURSES

10. Have you ever experienced workplace violence? Yes ( ) No ( )
11. Have you experienced workplace violence in the last twelve months? Yes ( ) No ( )

12. How often do you experience behaviours that can be interpreted as workplace violence? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( ) Never ( )
13. Do you know someone who has experienced workplace violence in UBTH apart from you? Yes ( ) No ( )
14. How often do you experience verbal altercations (e.g. threats, abuse, exaggerated arguments, offensive comments, etc) at your workplace? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( ) Never ( )
15. How often do you experience physical assaults without a weapon (e.g. slapping, beating, vandalising) at your workplace? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( ) Never ( )
16. How often do you experience physical assaults with a weapon (e.g. slapping, beating, vandalising) at your workplace? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( ) Never ( )
17. How often do you experience sexual harassment at your workplace? Daily ( ) Weekly ( ) Monthly ( ) Yearly ( ) Never ( )

SECTION C: PATTERNS OF WORKPLACE VIOLENCE AGAINST NURSES

This section focuses on identifying pattern s of workplace violence within UBTH. Select all that apply.

18. What forms of workplace violence do you know of? Verbal abuse ( ) Physical assault with a weapon ( ) Physical assault without a weapon ( ) Sexual harassment ( )
19. What forms of workplace violence have you experienced? Verbal abuse ( ) Physical assault with a weapon ( ) Physical assault without a weapon ( ) Sexual harassment ( )
20. Who carried out the act of workplace violence you saw? Patient(s) ( ) Patient's relative(s) ( ) Patient's caregiver (s) ( ) Other nurses ( ) Other healthcare workers ( )
21. Who carried out the act of workplace violence you experienced? Patient(s) ( ) Patient's relative(s) ( ) Patient's caregiver(s) ( ) Other nurses ( ) Other healthcare workers ( )
22. Where was the act of workplace violence carried out? Male medical ward ( ) Female medical ward ( ) Male surgical ward ( ) Female surgical ward ( ) Emergency ward ( ) Maternity ward ( ) Oncological ward ( ) Paediatric ward ( ) Male psychiatry ward ( ) Female psychiatry ward ( ) Theatre ( )
23. At what time of the day was the act of workplace violence carried out? Morning ( ) Afternoon ( ) Evening ( ) Night ( )

SECTION D: DETERMINANTS OF WORKPLACE VIOLENCE AGAINST NURSES

This domain seems to identify the various risk factors associated with workplace violence against nurses. What is your opinion regarding the importance of the following parameters as a reason for workplace violence against nurses in UBTH?

(Please answer the following questions using this key: SA= Strongly agree; A= Agree; N= Neutral; D= Disagree; SD= Strongly Disagree)

S/N	DETERMINANTS	SA	A	I	D	SD

24.	Unrealistic expectations of patients/relatives promote workplace violence against nurses					
25.	Wrong knowledge about the disease/health condition by patients and their caregivers promotes workplace violence against nurses					
26.	Inadequate knowledge about the disease/health condition by the patient can result in workplace violence against nurses					
27.	Poor communication skills can cause workplace violence against nurses					
28.	Lack of resources (equipment, drugs, nurse-patient ratio, etc) can result in workplace violence against nurses					
29.	Overcrowding can cause workplace violence against nurses					
30.	Long waiting time can lead to workplace violence against nurses					
31.	Inadequate security arrangement can promote workplace violence against nurses					
32.	Lack of provision of harsh punishments for aggressors/offenders can lead to workplace violence against nurses					
33.	Lack of respect for the authority of nurses can cause workplace violence against nurses					
34.	Negative and inappropriate media reporting can result in workplace violence against nurses					
35.	Workplace violence against nurses only happens to female nurses					
36.	Social attributes (race, ethnicity, social status, etc) is a major determinant of workplace violence against nurses					
37.	The higher the grade of the nurse, the less likely the chances of suffering from workplace violence					
38.	Nurses in the clinic do not suffer from workplace violence					

SECTION E: MEASURES TO CURB WORKPLACE VIOLENCE AGAINST NURSES

This domain focuses on the strategies that are in place in preventing episodes of violence against nurses in their workplace in UBTH. Which of the following measures are in place in UBTH?

39. Controlling the number of visitors with a patient per time can help reduce workplace violence. Yes ( ) No ( )

40. Educating patients and relatives about the limitations of medical sciences and the available infrastructure will help in curbing workplace violence. Yes ( ) No ( )

41. Regular training of healthcare workers regarding soft skills (communication skills, 'breaking bad news', counselling skills, problem-solving skills) will result in less cases of workplace violence. Yes ( ) No ( )

42. Self-defense training of healthcare workers will help to control the occurrence of workplace violence. Yes ( ) No ( )

43. Improving healthcare facilities (e.g. nurse-patient ratio, population-bed ratio, etc) can contribute to decreased rate of workplace violence. Yes ( ) No ( )

44. The availability of metal detectors to check for weapons among visitors will contribute towards a decreasing rate of workplace violence. Yes ( ) No ( )

45. The availability of alarm systems to alert security personnel will contribute towards a decreasing rate of workplace violence. Yes ( ) No ( )

46. Strong legislative measures (e.g. provision of significant punishment for offenders) will serve as a deterrent for people who partake in workplace violence. Yes ( ) No ( )

47. Security personnel strategically positioned in areas of sight within the hospital can reduce the occurrence of workplace violence. Yes ( ) No ( )

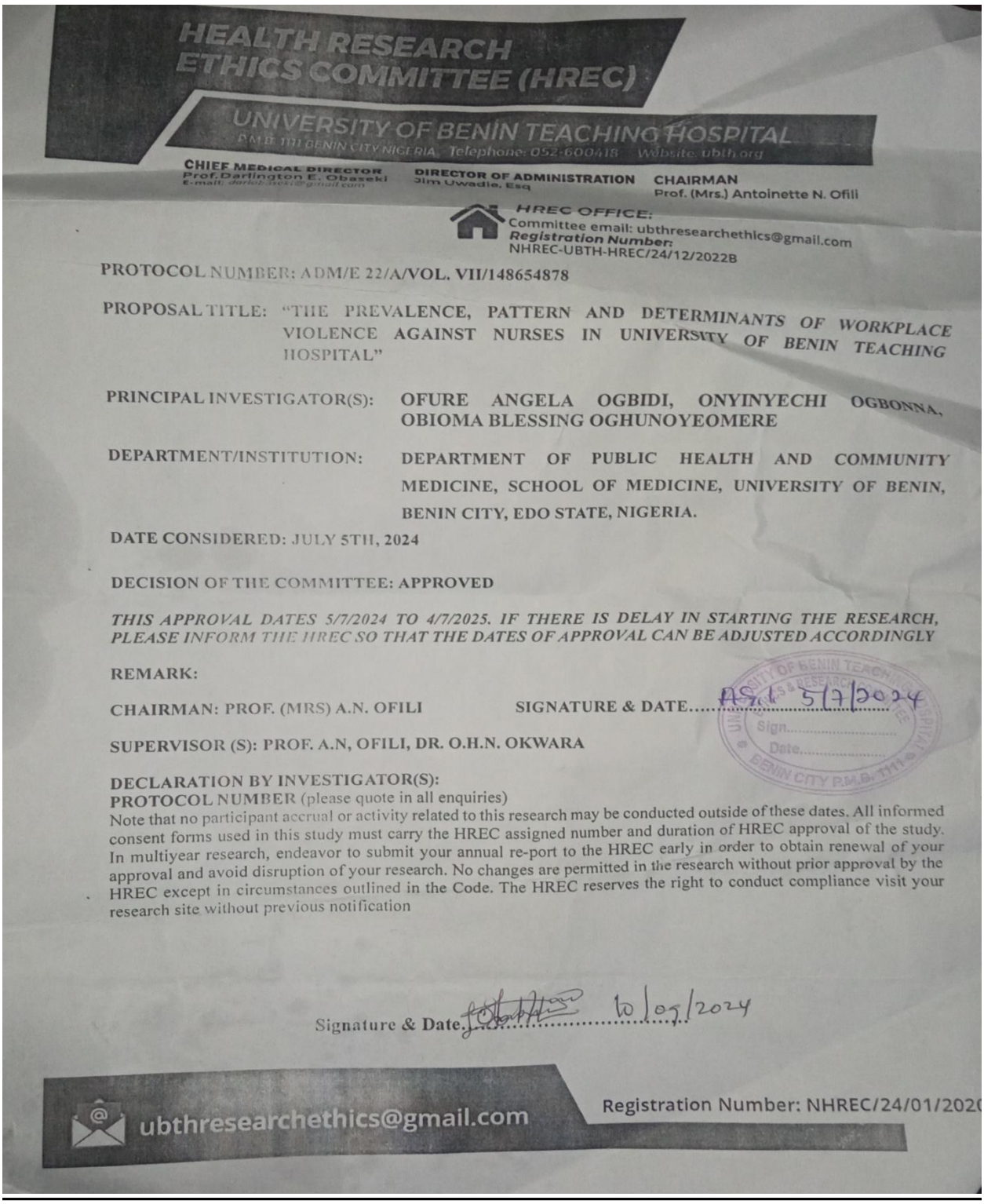
48. Unbiased media reporting plays a key role in preventing workplace violence. Yes ( ) No ( )

49. Sensitizing politicians and public figures not to give immature/negative statements regarding nurses can help reduce workplace violence. Yes ( ) No ( )

50. Appropriate compensation of victimized nurses will help prevent workplace violence. Yes ( ) No ( )

APPENDIX III

ETHICAL CLEARANCE FORM



HEALTH RESEARCH ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

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Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL. VII/148654878

PROPOSAL TITLE: "THE PREVALENCE, PATTERN AND DETERMINANTS OF WORKPLACE VIOLENCE AGAINST NURSES IN UNIVERSITY OF BENIN TEACHING HOSPITAL"

PRINCIPAL INVESTIGATOR(S): OFURE ANGELA OGBIDI, ONYINYECHI OGBONNA, OBIOMA BLESSING OGHUNOYEOMERE

DEPARTMENT/INSTITUTION: DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE, NIGERIA.

DATE CONSIDERED: JULY 5TH, 2024

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 5/7/2024 TO 4/7/2025. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI SIGNATURE & DATE..... 5/7/2024

Sign.....
Date.....

SUPERVISOR (S): PROF. A.N, OFILI, DR. O.H.N. OKWARA

DECLARATION BY INVESTIGATOR(S):
PROTOCOL NUMBER (please quote in all enquiries)
Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual re-port to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification

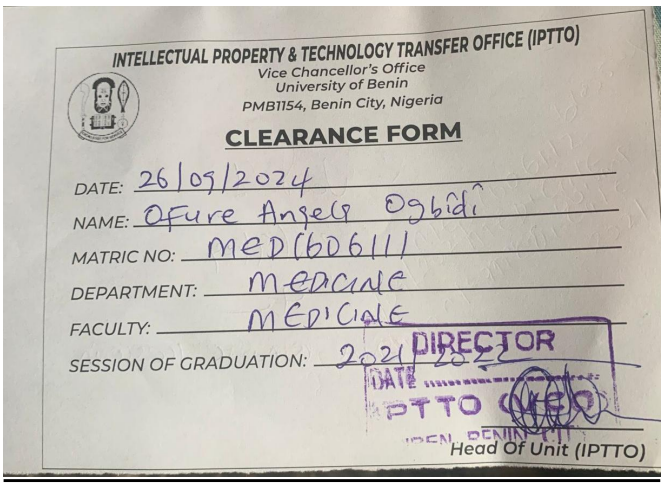
Signature & Date..... 10/09/2024

ubthresearchethics@gmail.com

Registration Number: NHREC/24/01/202

APPENDIX IV

PLAGIARISM CLEARANCE FORM



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CLEARANCE FORM

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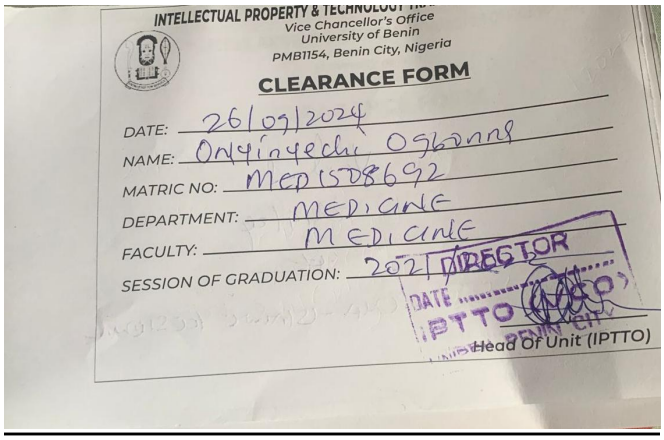
DEPARTMENT: MEDICINE
FACULTY: MEDICINE
SESSION OF GRADUATION: 2021/2022

DIRECTOR
DATE .....
IPTTO (UNIBEN)
Head Of Unit (IPTTO)



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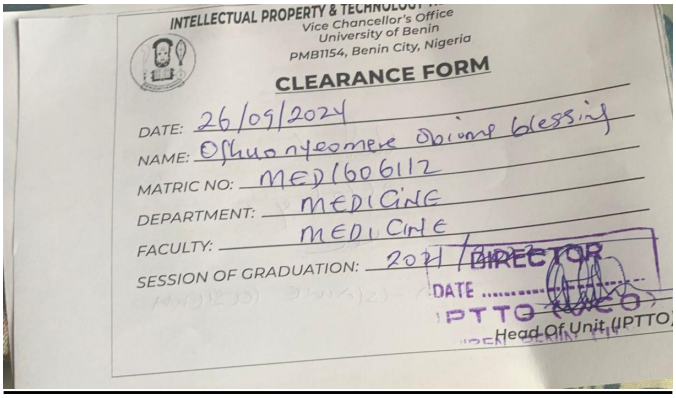
Head Of Unit (IPTTO)



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FACULTY: MEDICINE
SESSION OF GRADUATION: 2021/2022

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IPTTO (UNIBEN)
Head Of Unit (IPTTO)

APPENDIX V

INFORMED CONSENT FORM

TITLE OF STUDY: The Prevalence, Patterns and Determinants of Workplace Violence Against Nurses in the University of Benin Teaching Hospital.

INSTITUTION

The Department of Public Health and Community Medicine, College of Medical Sciences, University of Benin, Benin City.

PRINCIPAL INVESTIGATORS

Ofure Angela OGBIDI

Onyinyechi OGBONNA

Obioma OGHUONYEOMERE

SUPERVISORS

Prof. A.N. Ofili

Dr. O.H.N. Okwara

FINANCIAL SPONSORSHIP

This research work is financially sponsored by the principal investigators.

PURPOSE OF RESEARCH

The aim of this study is to identify the prevalence, pattern and determinants of workplace violence against nurses in the University of Benin Teaching Hospital with a view to provide data for appropriate policy formation to promote a better workplace atmosphere

PROCEDURES INVOLVED IN THE STUDY

Participants (nurses in the University of Benin Teaching Hospital) will be asked questions regarding the prevalence, pattern and determinants of workplace violence against nurses and the measures that have been taken to curb them in the University of Benin Teaching Hospital

CONFIDENTIALITY

All information collected will be kept confidential and stored securely. The data collected will be anonymised and only accessible to the research team.

COMPENSATION

Participants will not receive any compensation for their participation.

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. You may withdraw from the study at any time, without any consequences.

RISK

There are no risks associated with participation in this study.

BENEFIT

Participants would contribute to important research that may help improve public health promotion strategies. The results obtained from this research work would help identify the prevalence, pattern and determinants of workplace violence against nurses in the University of Benin Teaching Hospital**.**

CONTACT INFORMATION

If you have any questions or concerns regarding this research work, please contact:

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Department of Public Health and Community Medicine, UBTH, Benin City, Edo State, Nigeria.

Ethics and Research Committee,

Email: ubthresearch@gmail.com

Phone Number: 07063331337

IF THERE IS ANY PORTION OF THIS CONSENT AGREEMENT THAT YOU DO NOT UNDERSTAND, ASK THE FIELD WORKER OR INVESTIGATOR BEFORE SIGNING.

Please, sign below if you have agreed to participate in the study.

CERTIFICATION OF CONSENT

I, ……. having full capacity to consent for myself do thereby consent to my participation in the research study.

The methods and means by which the study will be conducted have been explained to me by the Ethical Committee. I have been given the opportunity to ask questions concerning this investigational study, and any such questions have been answered to my full and complete satisfaction.

I understand that I may at any time during the course of this study revoke this consent and withdraw myself from this study without prejudice.

Participant's Signature: _____

Date: _____